CHAPTER 59 BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICAL HEALTH SERVICES

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REFERENCES: A.R.S. §§36-2904 and 2905.01; A.A.C. R9-22 A.A.C. R9-28 42; 42 CFR 433.135, 42 CFR 438.114; ACOM 432 Attachment A

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

This policy outlines the fiscal responsibility for physical and behavioral health services for specific circumstances as well as benefit coordination between physical and behavioral health services. Payment for covered behavioral health and physical health services is determined by the principal diagnosis appearing on a claim, except in limited circumstances as described in AHCCCS Contractor Operations Manual (ACOM) 432 Attachment A-Matrix of Financial Responsibility by Responsible Party.

This Policy does not apply to services provided through Indian Health Services (IHS) or Tribally owned and/or operated facilities.

This policy is not intended to address all scenarios involving payment responsibility. For additional information not found within this policy, please refer to the Division contract (Amendment 62), ACOM 432, and ACOM 432 Attachment A.

A. General Requirements

The following apply for physical and behavioral health payments:

1. Regardless of setting, if physical health services are listed on a claim with a principal diagnosis of behavioral health, the Behavioral Health Entity is responsible for payment of covered physical health services as well as behavioral health services.

2. Regardless of setting, if behavioral health services are listed on a claim with a principal diagnosis of physical health, the AdSS is responsible for payment of covered behavioral health services as well as physical health services.

3. Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the professional claim. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim must not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity which authorized the inpatient stay.

4. Payment for an emergency department facility claim of an acute care facility including triage and diagnostic tests, when there is no admission to the facility, is the responsibility of the AdSS regardless of the Principal Diagnosis

on the facility claim. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim. Payment responsibility for the emergency department visit and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim must not be denied by the responsible entity due to lack of notification of the emergency department visit.

5. All Division services must be medically necessary, cost effective, and federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712.60 et seq. The AdSS and Behavioral Health Entities may enter into contracts with providers that delineate other payment terms, including responsibility for payment.

B. Behavioral and Physical Health Responsibilities

1. The following apply to payment for Behavioral Health (BH) services:

a. The AdSS must coordinate with the Behavioral Health Entity when both physical and behavioral health services are rendered during an inpatient stay and the AdSS is notified of the stay. Such coordination must include, but is not limited to: communication/ collaboration of authorizations, determinations of medical necessity, and concurrent reviews.

b. When the Principal Diagnosis on an inpatient claim is a behavioral health diagnosis, the Behavioral Health Entity must not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the AdSS authorized and/or determined medical necessity of the stay through concurrent review, such as when the admitting diagnosis is a physical health diagnosis.

The AdSS is responsible for reimbursement of services associated with a PCP visit for diagnosis and treatment of depression, anxiety and/or attention deficit hyperactive disorder including professional fees, related prescriptions, laboratory and other diagnostic tests. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment.

The AdSS is also responsible for payment of medication management services provided by the PCP while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the Behavioral Health Entity. For purposes of medication management, it is not required that the PCP be the member's assigned PCP.

2. The following apply to payment for Physical Health (PH) services:

   The AdSS must cover and pay for emergency services regardless of whether the provider that furnishes the service has a Contract with the AdSS. The AdSS may not deny payment for treatment obtained under either of the following circumstances [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)]:

   a. A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition 42 CFR 438.114.

   b. A representative of the AdSS (an employee or subcontracting provider) instructs the member to seek emergency medical services.

3. Additionally, the AdSS may not:

   a. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

   b. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the AdSS of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claim submissions by the hospital within 10 calendar days of the member's presentation for emergency services, constitutes notice to the AdSS. This notification stipulation is only related to the provision of emergency services [42 CFR 438.114(d)(1)(ii)].

   c. Require notification of Emergency Department treat and release visits as a condition of payment unless the AdSS has prior approval of Division.

4. When members present in an emergency room setting, the AdSS is responsible for payment of all emergency room services and transportation for all members regardless of the principal diagnosis on the emergency room and/or transportation claim.

   In the absence of a Contract between the AdSS and a hospital providing otherwise, the AdSS must reimburse hospitals for inpatient and outpatient hospital services as required by A.R.S. §§ 36-2904 and 2905.01, and 9 A.A.C. 22, Article 7, which includes without limitation: reimbursement of the majority of inpatient hospital services with discharge dates on and after October 1, 2014, using the APR-DRG payment methodology in A.A.C. R9-22-712.60 through A.A.C. R9-22-712.81; reimbursement of limited inpatient hospital services with discharge dates on and after October 1, 2014, using per diem rates described in A.A.C. R9-22-712.61; and, in Pima and

Maricopa Counties, payment to non-contracted hospitals at 95% of the amounts otherwise payable for inpatient services.

5. The following apply to payment for Physical Health (PH) services residing in the Arizona State Hospital (AzSH):

   a. The AdSS must provide reimbursement for medically necessary physical health services under one of the two following arrangements:

   b. A contractual agreement with Maricopa Integrated Health Systems (MIHS) clinics including Maricopa Medical Center (MMC) and MIHS physicians, to provide all medically necessary services. MIHS will be assigned to provide primary care services for all members residing in AzSH, or

   c. In the absence of a contractual agreement, the AdSS must be responsible for coordination of care, prior authorization processes, claims payments, and provider and member issues for all services delivered by MIHS. The AdSS must provide a seamless and obstacle free process for the provision of services and payment.

6. Emergency services for AzSH residents will be provided by the MMC and must be reimbursed by the AdSS regardless of prior authorization or notification.

7. Physical health related pharmacy services for AzSH residents will be provided by AzSH in consultation with the AdSS. The AdSS is responsible for such payment.

C. Benefit Coordination

The AdSS must coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. Title 9, Chapter 28, Article 9, so that costs for services otherwise payable by the AdSS are cost avoided or recovered from a liable third party [42 CFR 434.6(a)(9)]. The AdSS may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this policy. The two methods that will be used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The AdSS must use these methods as described in A.A.C. Title 9, Chapter 28, Article 9, federal and state law, and the Division's Provider Policy Manual Chapter 57 Third Party Liability. For the cost sharing responsibilities for members covered by both Medicare and Medicaid see the Division's Provider Policy Manual Chapter 16 Remittance Advice, Reimbursement, and Cost Sharing. [42 CFR 433 Subpart D, 42 CFR 447.20]

The AdSS must cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. There are limited circumstances when cost avoidance is prohibited, and then the AdSS must apply post-payment recovery processes.